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HEALTH SERVICES ADMINISTRATION

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Although the United States is generally perceived to have one of the best healthcare systems in the world, it was rated 37th among 191 ranked nations by the World Health Organization (WHO) in 2000. The Institute of Medicine (IOM) reported that many people are fatally injured by medical errors, and has called for sweeping changes in the healthcare delivery system. Assuming that American Medicine would benefit from improvement, what do you believe are the right approaches to make changes in the safety and effectiveness of health care delivery?

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The Institute of Medicine (IOM) Report indicated that many individuals in the U.S. are being harmed or fatally injured by medical errors. The result of the report was a recommendation that many critical changes need to be made in U.S. healthcare delivery in order to improve the safety and effectiveness of the system. The readings indicated that the types of changes required include: 1) a move toward greater incorporation of evidenced-based medicine (Clinical Practice Guidelines – CPGs); 2) health care leadership development; 3) information technology; 4) tort reform; and 5) responsiveness/values.

First, CPGs were mentioned as one way in which the error rate could be reduced, and thus increase the overall safety of the healthcare system. However CPGs are just that, "guidelines." If approached as such, they should improve quality and responsiveness, rather than hinder it as some suggest. CPGs will be an important part of any plan moving toward more evidence-based medicine. This will not be an overnight process, and more regulations mandating such changes with HIPAA deadlines and penalties is not the answer. Some administrative "controls" will probably be in order, but they should be reasonable. For example, CHCS allows for large variations in order entry that could be used quite effectively. Rather than completely restricting use of certain drugs, evidence-based and cost comparison guidelines should be built-in in such a way that they are brought to the attention of the provider at the time of order entry. However, controls on specific drug distribution should not be so absolute that "responsiveness" is lost based on a clinical reason to use another drug.

Drug distribution usage could be tracked (in a non-litigious environment) and dealt with through peer review where constructive criticism and clinical context could best be addressed to the benefit of that specific provider as well as others. In microsystems where this is appropriate patient input should be garnered. Patients may express a desire to be prescribed a proven drug

which is more expensive (with a proportional increased cost), as opposed to a less proven (i.e., newer), cheaper, but most likely just as effective alternative drug. The long-term and ultimate implementation of CPGs will involve numerous changes in the medical education process. For example, traditional Continuing Medical Education (CME) to talk about CPGs raises awareness, but has been shown to have little effect on healthcare professional behavior changes, according to the literature. Having a respected physician champion CPGs may help to a degree, and the one-on-one of "expert detailing" is very successful, albeit extremely expensive. Changes in the medical education requirements, in addition to changes in licensing, certification, and accreditation procedures will be essential to ensure that adequate attention is given to the concept of CPGs during medical school, internships and residencies. The early exposure, awareness, and hopefully, “buy-in” of future health care leaders may help gain momentum in achieving the desired goal of more universal implementation of evidence-based medicine.

In addition, given the political standing and degree of involvement of the medical community, enlisting their support will be crucial in reducing the costs of the healthcare system. It will also be important for patient/consumer education to be enhanced. Systems improvements are underway, but the individuals who make up the systems still need to be educated and convinced about new patient safety and quality expectations. These “systems” improvements can take the form of facilities improvements to support evidence-based practice, facilitating the use of information technology, aligning payment incentives, and changing the delivery mechanisms of diagnostic tests and procedures.

There are a number of specific areas within the healthcare delivery system where change should begin to happen. Berwick discussed these areas as “levels of interest.” These include level A, defined as the experience of patients, and level B described as the functioning of the

small “work units” or microsystems where people deliver care, together representing the doctor-patient relationship. In contrast, levels C and D are more global and outlined the functioning of the organizations which house or support the smaller work units (i.e., microsystems) and the environment where policy, payment, regulation, accreditation and other factors are dictated that serve to shape the behavior of those individuals in the organization at level C.

These “levels of interest” tie in closely with the second area in need of change that will help improve the effectiveness and safety of healthcare delivery - leadership. The Department of Defense (DoD) is currently a model for effective leadership in a healthcare system. However, there is an inherent responsibility for leadership changes at almost every level of the new reliable systems design, but the majority of leadership needed exists at levels B and C. If physicians maintain their traditional leadership roles, they will need increased training and education in both executive/management skills, as well as people skills in medical school and their residencies. At level A, it will begin with the experience of the patient and the communities. Level B represents the microsystems of care, or those small “work units” that deliver care to the patients/consumers. This is where the “quality of care” is perceived by the consumer, either good or bad. These patient perceptions could essentially be turned into market forces. In a pure market economy, this would be enough, and the best small units would rise to the top. However, the more nebulous level C (health care organizations) and level D (health care environment) must also support the changes, but the market will work more efficiently if there is more transparency. As the IOM report pointed out, getting the microsystems to adopt the “10 guiding principles” for redesign will work to enhance the effectiveness of those systems.

Another national goal for healthcare reform must be information technology. This will be critical for the optimal integration of responsiveness, CPGs, transparency and efficiency, as

well as many other healthcare delivery goals. The unanswered question, however, is “who” will fund it. It’s not likely that it will be HIPAA. However, left to natural market forces, there is a large source of under-tapped funds that could be used for financing, pure venture capital. If the amount of legislation and number of regulations were reduced and healthcare were treated as a “profit generating” enterprise, organizations that could show improvements in efficiency and quality through improved Information Technology (IT) would attract vast quantities of venture capital, especially in today's stock market climate.

A fourth area that must evolve in order for safety and effectiveness of the healthcare system to improve is that of tort reform. The majority of this change will happen at level D. This "medical" reform discussed in the IOM report must coincide with changes in litigation and regulation in order to ensure the environment is one that is more conducive to continual quality improvement. Physicians could be completely resistant to reporting medical errors voluntarily, even under the veil of anonymity, in such a highly competitive market and a world of never-ending lawsuits. Tort reform to improve transparency will allow for intra-organizational self-monitoring, resulting in internal system improvement and inter-organizational comparisons will become possible. Additionally, it will improve public accountability through market driven forces. The culture will necessarily have to change to the point that health care professionals can report adverse events without fear of reprisal. This may be possible taking a systems approach, thus minimizing blame when errors are made or outcomes are less than optimal, with a constant effort to develop system-wide oversight. Given a universal culture change resulting in U.S. tort reform, physicians and other providers may be more willing and able to focus on quality improvement since the attention would no longer center on "covering themselves" from legal action.

Finally, one must keep in mind that any of the changes made within the healthcare arena aimed at improving safety and effectiveness, must be in keeping with our American values. This is tantamount to the WHO report ranking the United States as number one on the "responsiveness" factor. In general, Americans highly value respect for individuals. This is really the "True North" perspective that Berwick mentions at the most basic level, "the front lines" of care, the doctor-patient interface. Keeping the patient foremost in the picture is the emphasis of many of the new patient safety programs, including DoD's. This also equates to involving patients in their own health care decisions and shifting some responsibility through improved information availability, wide choice of providers such as DCPs, and "customized" care. Our values and expectations of the U.S. healthcare system also include maintaining the dignity of individuals through confidentiality of records and prompt attention in emergency situations. Regardless of the WHO report that ranked the U.S. 37th of 191 nations, and the IOM report that called for sweeping changes to the healthcare delivery system due to fatal injuries caused by medical errors, the U.S. is generally perceived to have top-notch healthcare. Although it's not a perfect system, and changes can still be made to promote system-wide improvement, it is by far, the best healthcare system in the world.